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UNIVERSITY OF ALBERTA

THE RELATIONSHIP BETWEEN PARENTAL VALUE ORIENTATIONS AND PARENTAL PARTICIPATION IN HOSPITAL CARE

BY

C. M. NORRIS

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF NURSING

FACULTY OF NURSING

EDMONTON, ALBERTA

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **The Relationship Between Parental Value Orientations and Parental Participation in Hospital Care** submitted by **Colleen M. Norris** in partial fulfillment of the requirements for the degree of **Master of Science** in **Nursing.**

Dr. P. Brink (Supervisor)

Dr. R. Elliott

Dr. M. Gillespie

March 20, 1992

DEDICATION

To my mother whose strength, wisdom and love have supported me unconditionally through out my life.

To my father who taught us to respect and pursue all of our educational dreams.

To Adam who continues to challenge me to do better "Carpe Diem".

To Emeleigh and Ben who've enriched my life immeasurably.

Thank-you all. This is because of you.

ABSTRACT

This study explores the relationship between parents' values and their attitudes toward participation in the hospital care of their preschool-aged children. A descriptive survey was used to examine the association between parents' value orientations, participation attitudes, age, education, gender, the number of hospitalizations for the child, and the number of siblings in the home.

Data was collected through a questionnaire that comprised three instruments -- the Value Orientation Questionnaire developed by Kluckhohn and Strodtbeck (1961), the Parental Participation Attitude Scale (PPAS) developed by Seidl and adapted by Beck (1973), and a demographic data questionnaire. Respondents completed the questionnaires independently. The sample consisted of 37 consenting parents of preschool-aged children in Edmonton. Subjects ranged from 25 to 48 years of age.

Findings indicated that the parents in the study had an overall positive attitude towards participation. There was a significant relationship demonstrated between the individualistic relational orientation and

a positive attitude toward parental participation. As well, there was a significant relationship between the past time preference and a negative attitude toward parental participation. Results also included a parental value orientation profile.

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CHAPTER I

INTRODUCTION

When a child under sixteen years of age is admitted to a hospital, a parent or legal guardian must consent to any treatment that the child will receive. In the past, this was often where parents' participation in their child's care ended. For some parents this level of participation in the care of their hospitalized child is acceptable; for others, it is not. Understanding a parent's values and attitudes toward participating in the care of a hospitalized child provides insight into his or her probable level of participation. This information is essential to plan care and programs in paediatric hospitals.

A number of studies have attempted to list or define parents' typical behaviours during the hospitalization of their child. While some of the research acknowledges differing participation levels and desires, few studies address the possible reasons for such variations. More recently, studies of parents' attitudes toward participation have also begun to examine parents' perceptions of their levels of

participation. The literature review yielded no studies of the values upon which attitudes toward participation were based. In order to truly assess parents' attitudes toward participation it is necessary to examine the values upon which those attitudes are based.

Canadians possess a variety of culturally bound values and attitudes towards health and health care. Commenting on family participation in hospital care for children, Bell and Bell noted that "Participation of the family in hospital care is not an exotic curiosity, but a natural expression of family conviction strongly adhered to in three-fourths of the world" (1970, p. 157). They also identified that family participation in hospitals is uncommon in Western cultures. Parents generally recognize the importance of being present during the hospitalization of their child, yet non participation is typical of most Canadian families. Patients from other cultures are often frustrated and confused by hospital ideals and expectations that prevent family members from participating in the care of a child in a Canadian health care facility.

In 1961, Kluckhohn and Strodtbeck developed a questionnaire to measure cultural value orientations.

The original study identified core American values. Since then, value orientation research has been done for various cultural groups. Data are available on the value orientations of the Annang of Nigeria, for example (Brink, 1984). These studies provide the background for this study of the relationship between parents' value orientations, and attitudes toward participation. The associations between parents' value orientations and attitudes toward their participation have not yet been examined. Research in this area will inform health care workers of the attitudes toward participation that may be expected from a parent who has certain cultural values.

Purpose

The purpose of this study is to determine whether there is a relationship between parents' value orientations and their attitudes toward participation in the care of a hospitalized preschool-aged child in Edmonton.

Definition of Terms

Value Orientations:

These are culturally based ranking of solutions to four common human problems -- Man-Nature, Time, Activity, and Relational as measured by the Value Orientation Questionnaire.

Attitudes Towards Participation:

These relate to the level of a parent's involvement or non-involvement in the hospital care of a preschooler as measured by a score greater than 78, on the Parental Participation Attitude Scale (PPAS) indicating a positive attitude or a score equal to or less than 78 on the PPAS, indicating a negative attitude.

CHAPTER II

REVIEW OF THE LITERATURE

Parental Participation from a Historical Perspective

In the late 1800s, the first hospital for sick children -- The Great Ormond Street Hospital in London, England-- was built. Until that time, children under two years of age had not been admitted to hospital, as they inevitably died of infections acquired there. Mothers cared for their sick children at home.

Unfortunately, the health care professionals lack of experience in caring for children and the hospitals lack of physical space to accommodate mothers, meant that children acquired and died of cross-infections in hospital. In response to this situation, the matron in charge of nurses at the Great Ormond Street Hospital started a hospital-based school of nursing. The School for Sick Children's Nurses continues today to train nurses specialized in the care of children.

Although nurses became better qualified to care for the children, one nurse still cared for a number of children at one time. This fact, combined with a lack

of knowledge about aseptic techniques, yielded almost the same number of deaths as before.

Physicians too searched for solutions to combat the problem of cross-infection in children. From 1928 to 1942, Pickerill & Pickerill, ran a program in which mothers of infants requiring cleft palate repair were asked to come to the hospital to care for their infants (1959). They felt that one-to-one care would prevent the problem of nosocomial infections among the infants. The Pickerills' study demonstrated that having mothers care for their infants in hospital virtually wiped out the deaths due to hospital-acquired infections.

The elimination of cross-infections was the primary motivation for the Pickerills' program; in addition, the psychological needs of children in hospital were beginning to be addressed. An aside to their study, the Pickerills noted that "A mother can exert a great effect on her small offspring, she is not only the best possible sedative, but a stimulator of life, happiness, and even euphoria." (1959, p. 426). In a presentation to the Royal College of Physicians in London, Dr. J.C. Spence (1947), suggested that a solution to the problem of cross-infections among

hospitalized children could be found in admitting mothers to the hospital to nurse their own children. He stated that children's hospitals were modelled after adult hospitals and therefore lacked the nursing staff for infants and accommodation for mothers. Hospitals, rather than medical personnel, had in effect prevented parents from caring for their sick children in hospital.

The evolution of children's health care in North America was similar to that in England. In 1888, shortly after the opening of the Great Ormond Street Hospital in England, the first North American hospital for sick children opened in Philadelphia. A Department of Paediatrics was started at the Harvard Medical School at the same time; however it was not until 1913 that the first full-time chair was established at the Johns Hopkins Medical School and paediatric departments began to appear in all medical schools. As paediatric medicine became more entrenched in the medical schools, paediatric treatment was introduced in the general hospitals. As in England, these general hospitals were built to accommodate adult patients without family members.

In the 1950s John Bowlby, a leading expert on the attachment behaviours of children, conducted research on behalf of the World Health Organization (WHO). His research into the mental health needs of homeless children confirmed observations he had previously made with his colleague James Robertson in the 1940s. Bowlby and Robertson had investigated the effects of the separation of children from their mothers in early childhood on the personality development of children. Based on their empirical observational studies, (Robertson & Bowlby, 1952, Bowlby, 1953, Robertson, 1953) Bowlby concluded that one could not overemphasize the importance of the maternal-infant bond. He also outlined the need for an attachment-figure during hospitalization to ensure the mental health of children (Bowlby, 1952). Until the publication of the WHO report there had been little agreement about the significance or relevance of maternal-child separation.

Following the WHO report Bowlby developed and published his theory on maternal-child attachment and separation in a three volume series entitled Attachment and Loss (1969, 1973, 1980). Although the influence of psychoanlytic theory was pervasive in Bowlby's

attachment theory, Bretherton and Waters (1985) state that Bowlby formulated attachment theory based on the findings from Bender and Yarnell (1941), Goldfarb (1943), Skoday and Skeels (1949), and Spitz (1946). These findings demonstrated pervasive ill effects of institutional and hospital care on infants and young children, ages 6 months to 6 years. Bowlby believed that the repercussions of maternal-child separation were life long. Spitz (1946) was the first to identify that the separation of the mother from the infant was responsible for the withdrawal behaviors of the infant. Spitz's work however, was limited to infants up to the age of two and one half years. From these early beginnings health care professionals began to recognize the importance of the maternal infant bond.

Care by Parent Units (CBPUS)

Recognition of the importance of a parent's presence, coupled with budget cutbacks and a shortage of nursing personnel, led some health care administrators, to institute programs that required parents to be responsible for their child's care in

hospital. The first Care by Parent Unit (CBPU), as they came to be known, opened its doors in Kentucky in 1967. There are only three care-by-parent units in Canada located in Vancouver, Halifax and Edmonton.

CBPUs are hospital-based units that accommodate paediatric patients as well as their parents, so that parents can care for their children in hospital. A manager, much like an office manager, is present during the day to manage the unit. Present-day CBPUs also have a nurse available to the families for teaching and consultation on week days. A nurse can be reached during the night by contacting another unit in the hospital or the nursing supervisor. The types of paediatric patients admitted to CBPUs range from children requiring in-hospital tests to children requiring continuous monitoring.

A number of articles (Lerner et al., 1972, Monahan & Schkade, 1985, Vass Fore & Holmes ,1983) describe CBPUs' admitting policies and day-to-day operations. Some researchers have used questionnaires to evaluate CBPUs effectiveness (Learner et al., 1972). Evaluations of CBPUs conclude that CBPUs are cost-effective and positively accepted by parents, and medical and nursing

staff (Evans & Robinson, 1983, Vass Fore & Holmes, 1983). None of the articles address either the reliability or validity of the questionnaires. CBPUs indisputably meet a child's need for the presence of his or her parent. Whether or not the CBPUs consistently meet the need of the parents to choose a comfortable level of participation is an issue that has not been addressed.

Parents Attitudes Towards Participation

Several researchers have used checklists to describe parents' attitudes to activities that they could or did participate in while their child was hospitalized (Hill,1978; MacDonald, 1969; Merrow & Johnson, 1968; Webb, Hull, & Madeley, 1985). These checklists included parental activities customarily done at home; for example, feeding, changing and comforting the child, as well as those activities commonly regarded as "nursing activities". Nursing activities included technical actions such as taking temperatures and giving medications. None of the above studies, however, indicated why parents chose the activities on the checklists. Although there was

minimal reporting of the methods, these studies, provide information of value to the study of parental participation. Two studies used qualitative approaches, such as open-ended questions, diaries, and interviews, to develop a data base of parental participative activities (Knafl et al., 1986, Stull & Deatrick, 1986).

Beck adapted the Parental Participation Attitude Scale (PPAS) to study parents' attitudes toward participating in their children's hospital care (1973). Using a 5-point Likert-type scale, Beck's study asked parents if they agreed or disagreed with statements regarding parental participation. Beck's results indicated that 84% of the 38 participating parents demonstrated positive attitudes toward parental participation. No statistical relationship was found between the respondent's age, educational level, or socioeconomic class and the attitude scores. Beck provided some explanations for these results. She postulated that the readability level of the questionnaire was too high, and that the respondent's unfamiliarity with the Likert-type scale and embarrassment due to age and level of education may

have been significant factors.

O'Connor Reid (1984) replicated Beck's study in a paediatric intensive care unit in Texas. The results of O'Connor Reid's study concurred with Beck's, although the small sample size of parents (10 parents) was not addressed.

Health Care Worker's Attitudes Toward Participation

The third category in the literature on parental participation includes studies that examine reasons parental participation typically has not been encouraged by health care workers. Several of these articles address nurses' attitudes toward parents' participation in their children's care. The most frequently cited study in this area was done by F.W. Seidl in 1969. Seidl developed - the Parent Participation Attitude Scale (PPAS), to measure nurses' attitudes toward parental participation. This study demonstrated that nurses with higher formal education, higher social ranking, and young children at home had more accepting attitudes toward parental participation. Seidl suggested that these nurses related more closely to the parents not only due to the ages of their own children but also because they had been educated in

degree programs that fostered "family-centered care". Consequently, they had more positive attitudes toward participation.

As well as concurring with Seidl's results, Dunn's replicative study (1979) found that a nurse's age, positively affected his or her attitude to parental participation. Nurses between the ages of 25 and 38 years were most likely to have a positive attitude toward parental participation. Gill, too (1987) has replicated and corroborated Seidl and Dunn's study results (Gill,1981,1985,1987). In addition, Gill (1985) found that nurses with Masters' degrees had the highest mean positive attitude scores. In contrast, O'Connor Reid (1984) found there were no significant differences in nurses' attitudes according to the type of nursing degree held.

In Paediatric Hospitalization - Family and Nurse Perspective, Knafl et al. (1988) examined nurses and parents' attitudes to the activities parents participated in while their child was in hospital. They concluded that there was a wide discrepancy between nurses and parents' attitudes about the appropriate levels of participation. One reason given for this

discrepancy was the difference between nurses and parents' levels of education. As well, Knafl et al. addressed the question of whether the number of hospitalizations influenced the level of parental participation. Their results indicated there was a relationship between the two variables but that further study would be required to be more definitive. Knafl et al. also looked at variables that may influence a parent's level of participation, including income, level of education, occupation, the number of siblings at home, and whether the parent worked outside the home. Knafl et al. concluded that the demographic characteristics did not differ between the levels of participation.

Various other explanations for the lack of parental participation have been explored. Ayer (1978) states that lack of space, therapeutic considerations, staffing considerations, and nurses' own needs are reasons frequently given by nurses as to why parental participation is not routinely practised. Ayer further argued that these are "excuses" and that methods for the implementation of parental participation must be introduced.

Fagin and Nasbaum (1978) argued that encouragement or lack of encouragement from the nursing administration directly affected the amount of parental participation. Deatrick (1984) believed that parents who stopped participating in their adolescents' hospital care were attempting to help their children to care for themselves. In a survey of paediatric units in Canadian hospitals, Post, Powers and Baskerville,(1987) reported that the reason cited most frequently for the lack of parental participation was that parents did not wish to assume responsibility for the technical aspects of care. Recent explanations for negative attitudes towards participation include: a lack of understanding by nurses of the various helping models (Dunst, Trivette, Davis, & Cornwall,1988), and a "poor fit" between a child and a parent's temperament (McClowry, 1990).

Summary

In summary, the literature on parental participation in the care of a hospitalized child include 's : information on CBPUs, including their advantages and disadvantages; parents' attitudes toward participation; health care workers' attitudes toward

parental participation; and hypotheses as to factors that prevent parents from participating.

As pointed out by Knalf et al.(1988), parents in general recognize the importance of being present during the hospitalization of their child. A review of the literature yielded a number of studies, albeit methodologically inadequate, that attempted to list or define typical parent behaviours. While some articles acknowledge differing participation levels and desires, few studies have addressed possible reasons for such variations. Studies on attitudes towards participation have begun to examine parents' perceptions of their levels of participation. Studies could not be found that examined the values that underlie the attitudes toward participation. To assess parents' attitudes toward participation we must examine the values upon which those attitudes are based.

Value Orientation Studies

Values have been discussed by scholars of various disciplines for years. As children we acquire our values from interacting with our significant others and

observing their interactions with others. We acquire our values from observing individuals in the culture in which we are raised. As a result the values that we learn and assimilate are culturally based.

One scholar who believed that values were culturally based was Florence Kluckhohn. Kluckhohn's theory of value orientations suggests that there are a limited number of common human problems. As well, these problems's solutions (of which there are also a limited number), are culturally based.

In 1961, Kluckhohn along with her colleague Fred L. Strodtbeck, published a study in which they had developed and tested a schedule to measure the value orientations of five different cultural groups in the United States.

Kluckhohn and Strodtbeck based the development of the assessment tool on three assumptions. Firstly, "there is a limited number of common human problems for which all people at all times must find some solution" (p. 10). Kluckhohn and Strodtbeck limited the number of common human problems to five.

1. The relationship of the person to nature.
2. The temporal (time) focus of human life.
3. The modality of human activities.

4. The modality of a person's relationship to other people.
5. The nature of man.

Although Kluckhohn and Strodtbeck identified five common problems, they did not investigate the fifth problem: "Limitation of time and research funds prevented the development of items which would test all three alternatives of this orientation and also precluded any consideration of the human nature orientation" (p. 77). Therefore, this fifth orientation was also not addressed by the present study.

The second assumption was that, "while there is variability in solutions of all problems, it is neither limitless nor random but is definitely variable within a range of possible solutions" (p. 10). Kluckhohn and Strodtbeck identified three solutions for each problem. (except the Activity problem, which had only two solutions.)

The third assumption was that "all alternatives of all solutions are present in all societies at all times but are differently preferred" (p. 10). Kluckhohn and Strodtbeck believed that there was in every culture a dominant value orientation for each of the common human problems and also one or more

variant value orientations for each problem. The findings of Kluckhohn and Strodtbeck indicated that there were differences in the value orientations of the five cultural groups they studied although the groups shared common geographical proximity.

Several studies have utilized all or parts of the original Kluckhohn and Strodtbeck Value Orientation Questionnaire (VOQ). Caudill and Scarr (1962) used the scale to contrast the values of Japanese parents and their children. Their sample included of 619 respondents (253 parent-child groups). The children were high school students from three areas in Japan. After a child completed the schedule, his or her same-sex parent completed the questionnaire at home. This study concentrated on three of the original value orientations: Relational, Time and Man-Nature. The interesting difference from Kluckhohn and Strodtbeck's original study was that Caudill and Scarr's sample was from a single culture. Caudill and Scarr wished to look at the differences between the dominant and variant value orientations between generations. Caudill and Scarr also looked at the distance between the parents' and children's dominant orientations. Their theory was

that the greater the distance between each generation's dominant choices, the greater the change in values from one generation to the next. Thus, the greater the change in value orientations between the parents and children, the less value transmission between generations. The results of Caudill and Scarr's study demonstrated that younger Japanese preferred consensus in decision making (collateral relations), while older Japanese favoured the more traditional value orientation of lineal authority. They also found that younger Japanese had a greater commitment to the present and the past, while older Japanese chose the future as their first-ranked time choice.

In 1975, John Papajohn and John Spiegel published the results of their work with the Kluckhohn and Strodtbeck Value Orientation Questionnaire in Transactions in Families, Papajohn and Spiegel studied three immigrant families. One member in each of the families had suffered some form of mental illness generated by the stress of coping with conflicting value systems and role expectations. The authors contrasted the three immigrant families (Greek, Italian, and Puerto Rican) and their value orientations

to the American core value orientations as identified by Kluckhohn and Strodtbeck in their 1961 text.

Papajohn and Spiegel's study indicated that the psychological problems in these particular immigrant families could be traced to the fact that some family members had assimilated American core value orientations while others had retained their original country's dominant value orientations. This caused extreme stress for family members, particularly in decision making. The results indicated that respondents who were born in and spent their "formative years" (identified as approximately 20 years) in Greece adhered closely to traditional Greek value orientations.

Papajohn and Spiegel demonstrated the practical uses of the Value Orientation Questionnaire as an assessment tool and based the therapy provided to the families on the family members' individual value orientations.

Using Kluckhohn and Strodtbeck's Value Orientation Questionnaire, Tony Tripp-Reimer and Mary Cardwell Friedl (1977) demonstrated the contrasts that exist between American dominant value orientations, as

identified by Kluckhohn and Strodtbeck, and Appalachian dominant value orientations. Tripp-Reimer and Friedl illustrated the confusion and difficulties that arise when health care providers plan care based on their own value orientations rather than on the clients'. Using the Kluckhohn and Strodtbeck Questionnaire as a cultural assessment tool, Tripp-Reimer and Friedl planned interventions that were compatible with their clients' frames of reference.

Janice Egeland (1978) used a revised version of Kluckhohn and Strodtbeck's original Value Orientation Questionnaire to examine the health beliefs of five inner city groups in Florida. Egeland's questionnaire included five health-related items. To accommodate the additional five questions, two items from Kluckhohn and Strodtbeck's original questionnaire were dropped. The adapted questionnaire was then used with five cultural groups, including Haitians, Bahamians, Southern Blacks, Cubans, and Puerto Ricans, in the Miami area.

Egeland's study and report indicated that the addition of the health items to Kluckhohn and Strodtbeck's original questionnaire "produced a general lack of value ranking compared to the non-health

schedule items "(1976,p. 200). Egeland noted, however, that the use of this "misguided health item" questionnaire made the researchers appreciate more fully the reliability and the validity of the original Kluckhohn and Strodtbeck items. The results did indicate the dominant and variant value orientations of the different cultural groups included in the study.

Similarly, in 1976 Sharon Ogden Burke and Rita Maloney, adapted Kluckhohn and Strodtbeck's questionnaire to develop a sex specific questionnaire for women. The original Kluckhohn and Strodtbeck tool was modified to compare values among Euro-Canadians, rural Cree, urban Indian women and nurses. Ogden Burke and Maloney describe the revised tool which they called the Women's Value Orientation Schedule (WVOS). The WVOS contains five of the original VOQ items, eight edited items, and six revised stories. Ogden Burke and Maloney also mentioned that they were in the process of conducting another study using the WVOS.

Although Kluckhohn and Strodtbeck's questionnaire was used as a basis for the WVOS, the revisions in fact make this a unique schedule. Kluckhohn and Stodtbeck in describing the development of the original

questionnaire stated that a major concern in the development of the questionnaire was "the reduction of the effects of the purely idiosyncratic life experiences of particular individuals" (p. 79). Ogden Burke and Maloney's schedule included questions on topics such as miscarriages, care of children, and difficult births. The issue of whether the respondents were reacting to the content of the questions and, consequently, their own personal experiences, was not addressed by the authors. This fact severely limits the use of this schedule.

Robert T. Carter (1990) used the Kluckhohn and Strodtbeck questionnaire as a basis to compare the dominant value orientations of African-American and white-American college students. Carter, like Egeland, and Ogden Burke and Maloney, adapted Kluckhohn and Strodtbeck's original questionnaire and developed the Intercultural Values Inventory. The reported reliability coefficients for the 15 subscales of the inventory ranged from .54 to .79. The validity of the inventory is not addressed. The results of Carter's study indicated that African-American and white-Americans did differ significantly in value-orientation

preferences.

Lantz (1989) in an article entitled Family Culture and Ethnicity, discussed the influence of family values on attitudes toward health care, use of health care resources, and individual involvement in health promotion strategies. After presenting a brief review of the VOQ, Lantz suggested that nurses who understood the value orientations of families could better understand those families' decisions about health and health care.

In an article published in 1984, Pamela Brink described Kluckhohn and Strodtbeck's tool, and presented research describing the value orientations of the Annang of Nigeria. A deliberative sample was selected from the Afaha Obong clan of the Annang-speaking people of Nigeria to represent different educational levels, variant geographical areas, as well as clan members with different levels of seniority. Brink utilized the schedule to describe the value orientations of a single culture. The findings indicated that the Annang at the time of the study were in a "state of cultural flux" (Brink, p. 202).

As well as the Annang study, Brink also described

in detail how the Value Orientation Questionnaire could be used by health care providers as a cultural assessment tool. Brink (1984), Egeland (1978), Papajohn and Spiegel (1975), Tripp-Reimer and Friedl (1977), and Lantz (1989) all emphasized the difficulties that could arise when a health care providers' value orientations contrasted with the value orientations of their clients. Lack of awareness of an incongruence or conflict between a health care provider's and a patient's value orientations confuses and frustrates both the health care provider and the patient.

Canada is a country of inhabitants with contrasting culturally bound values and attitudes about health and health care. Bell and Bell (1970) noted "Participation of the family in hospital care is not an exotic curiosity, but a natural expression of family conviction strongly adhered to in three-fourths of the world" (p. 157). Bell and Bell also identified that family participation in hospitals is not a common Western practice. Non-participation is typical in most Canadian hospitals. Patients from other cultures may be frustrated and confused by Canadian hospital ideals and expectations. Family members attempting to participate

in the care of a child in a Canadian health care facility may be frustrated by Canadian hospital procedures.

The relationship between a parent's value orientations and his or her attitudes toward participating in hospital care could be essential in the care of a hospitalized child. The literature on parental participation indicates that researchers have addressed parents' attitudes towards participation in the hospital care of children, but have not looked at the values upon which those attitudes are based. It was anticipated that assessing the value orientations and attitudes of parents would show whether there was an association between parental value orientations and attitudes toward participation in the care of the hospitalized preschool-aged child. Health care providers could use the VOQ to assess the possible level of participation they can expect from parents of children entering the hospital.

CHAPTER III

METHODOLOGY

Research Design

A descriptive survey design (Brink & Wood, 1988) was used to examine the association between parental value orientations and attitudes toward participation in the care of a hospitalized preschooler.

Subject Recruitment

The target population included all parents of preschoolers in Edmonton. The original intent was to gather a random sample of parents of preschool children in Edmonton. In order to capture the various ethnic origins of the parents in the study, the target population was to be divided into four groups based on the geographical locations of the children's schools. These four groups would include schools located in the north, south, east, and west areas of Edmonton. The division between the north and south area groups would occur at the North Saskatchewan River. Schools located to the south of the river would be included in the

South Side group, and schools located to the north side of the river would be included in the North Side group. The division between the west and the east area groups would occur at 100th Street in Edmonton. Schools located to the west of 100th Street would be included in the west area group and schools located to the east of 100th Street would be included in the east area group.

Once the quadrants had been determined, five schools would be selected from each quadrant using a simple random selection technique. The names of all the schools in the areas would have been placed in a hat and five schools from each area would have been selected. One questionnaire was to be sent to the parents of each of the children registered in an Early Childhood Services (ECS) program in the selected schools. Given there was more than one child in the family only one questionnaire would have been sent to the family. This method of sample selection was discussed at length with the Research Coordinator for the Edmonton Public School Board and agreed upon in principle at that point. When the questionnaires were ready to be sent out to the parents, the Coordinator's

supervisor chose not to allow the researcher access to the list of parents and, consequently, did not allow the questionnaires to be sent.

I also attempted a second method to obtain a random sample of preschool parents. I requested access to the lists of parents of preschool children compiled by Public Health Units in Edmonton. A letter and a copy of the research proposal were sent to the Edmonton Board of Health Research Coordinator. Permission to access the subjects was not provided as the Board of Health Research Committee stated that the research was not applied nursing research.

As a result, a convenience sample of English-speaking and reading parents of preschool-aged children was used. Parents known to the researcher to have a child aged 3 to 5 years were approached as subjects. Verbal explanation of the research study's purpose was provided. Parents who agreed to participate were given a letter of explanation and a questionnaire in a return self-addressed envelope to maintain their anonymity. Sixty parents agreed to complete the questionnaire. A total of 37 parents returned the completed questionnaire.

Protection of Subjects

A number of methods were used to ensure the protection of the subjects in the study. The proposal for the study was presented and approved by the Faculty of Nursing Ethics Review Committee. Participation in the study was voluntary. Prospective parents were informed of the nature of the study and the degree of involvement by a cover letter. Confidentiality and anonymity were assured in several ways. Questionnaires were returned in self-addressed stamped envelopes. At no point was the respondent asked to give his or her name. Individual questionnaire data or information that would enable identification to be made did not appear in the study report nor in any publications or presentations resulting from the study. All data were presented as group data.

Instruments

Three measurement tools were used to measure the variables in this study. They included the original Value Orientation Questionnaire (VOQ) (see Appendix A), the Parental Participation Attitude Scale (PPAS) (see Appendix B), and a demographic data questionnaire (see

Appendix C).

The Value Orientation Questionnaire(VOQ)

The VOQ is a 22-item ordinal scale questionnaire. Each item contains a situation with three possible solutions. The respondent is asked to rank the best and the second-best solution to the situation provided. Each of the situations reflect one of the four modalities that Kluckhohn and Strodtbeck (1961) originally described as the four "common human problems." Each problem has three classes of solutions(except for Activity which has two). The names given to the value orientations related to each human problem are :

1. Man-Nature
2. Time
3. Activity
4. Relational

The Man-Nature orientation has three solutions from which to choose. They are Subjugation-to-Nature, Harmony-with-Nature, and Mastery-over-Nature. The Subjugation-to-Nature solution suggests that there is little one can do about problems such as floods, fire, and illness. In the Harmony-with-Nature solution, humans and nature are inseparable and a sense of well-being is based on their unity. In the Mastery-over-

Nature solution, natural forces of all kinds are overcome, and illness is controlled.

The three solutions of the Time orientation are Past, Present, and Future. These solutions are self-explanatory. Of particular interest to health cae professionals is the fact that the American health care system is primarily future-orientated.

The original questionnaire provided for only a two-solution ranking in the Activity problem. The two solutions are Doing and Being. The Doing solution emphasizes activities external to the acting individual. Kluckhohn and Strodtbeck identified this as an American core value. The Being activity emphasizes activity that expresses what is given in the human personality, i.e., the spontaneous expression of impulses and desires.

The Relational value orientation has three solutions: Lineal, Collateral, and Individualism. These solutions suggest ways people relate to one another and specifically how decisions are made. Lineal relations emphasize the descent from parent to child. Authority and decisions are passed down in a hierarchical manner. Collateral relations indicate that the decision making

is a group effort whereby consensus is reached by the group. Individualism, as the word suggests, indicates that the decisions are made on an individual basis and actions based on those decisions are carried out independently of others.

Kluckhohn and Strodtbeck established the construct validity of the Value Orientation Questionnaire in the evolution of the tool. The tool was used to test Kluckhohn and Strodtbeck's value orientation theory and was at the same time tested in five different cultures.

Kluckhohn and Strodtbeck established concurrent validity of the tool by doing concurrent ethnographic studies on the 5 cultural groups tested with the value orientation questionnaire. The results of the ethnographic studies supported the findings of Kluckhohn and Strodtbeck's value orientation research. As well, Kluckhohn and Strodtbeck correctly argued that the reason for the different responses to single items by different groups of respondents was due to "true cultural" differences, successfully indicating the construct validity of the original questionnaire items.

Reliability of the Value Orientation Questionnaire was not established in the original study: "due to the

limitations in time and research funds ... it was not possible either to carry out satisfactory pre-testing programs or to use standard replication procedures" (Kluckhohn & Strodtbeck,1961,p. x). Kluckhohn and Strodtbeck pointed out that this weakness was overcome by the fact that a large body of data were available to check the test results.

The Questionnaire has been used on various cultures over the past thirty years and the stability and accuracy of the Questionnaire have survived the test of time. Egeland (1978), who tested the reliability of an adapted VOQ questionnaire developed for her study, indicated that the only reliable items on the revised Value Orientation Questionnaire were those items originated by Kluckhohn and Strodtbeck in the original questionnaire.

Parental Participation Attitude Scale (PPAS)

Beck's (1973) Parental Participation Attitude Scale (PPAS) is an adaption of F. Seidl's (1969) rating scale. Parents completing Beck's PPAS were asked to respond to statements in terms of their approval or

disapproval. A 5-point Likert-type scale was used. Each of the items was weighted and the total score constituted the attitude of the parents towards parental participation. Tests for the reliability of Beck's scale were not provided in Beck (1973). O'Connor Reid (1984) assessed the reliability of Beck's instrument using the Cronbach's Alpha test for reliability. The coefficient Alpha for the parents' group was r =.45. As O'Connor Reid points out, this score could be due to the small (10 parents) homogeneous group of parents used in her study. Using the FOG index, O'Connor Reid's (1984) appraisal of the readability index, indicated that the scale instructions had a readability index of 6.5 years of schooling and the survey questions' readability index was 8.8 years of schooling.

Content validity for the original Seidl PPAS was established by using a panel of three nurses to judge whether each item met specific criteria for inclusion on the attitude scale. Although the validity of Beck's PPAS has not been addressed to date, a review of the literature on parental participation indicated that the content in Beck's PPAS was representative of the

material presently available.

Demographic Data Questionnaire

A demographic data questionnaire (see Appendix C) developed by the investigator was also used. Possible extraneous variables that may influence parents' attitudes towards participation were included. Although not of direct interest, they needed to be included in order to rule out other explanations for the results of the study. The questionnaire contained simple questions on the parents' age, marital status, education, employment status, occupation, number of children, ethnicity, primary language spoken at home, preferred language spoken at home,and the age at which the respondent moved to Canada. The three instruments were presented together in the form of a single questionnaire. Section I included the VOQ, Section II included Beck's PPAS and Section III included the demographic data questionnaire.

Reliability and Validity

Based on what is known to the researcher about value orientations and parental participation, the

tools that comprised the questionnaire used in the study had content and concurrent validity. A number of parents commented on problems completing the questionnaire. These included the length of time required to complete the questionnaire as well as distractions while completing the questionnaire. The presence of small children was frequently cited as a distraction. Parents commented that it would have been better to have been alone while completing the questionnaire.

Random errors in measurement may have been caused by variations in the parents' moods, or by distractions or fatigue experienced while completing the questionnaire. The physical environments in which the subjects completed the questionnaire may also have affected the results.

To reduce the random error in coding the data, 10% of the data were randomly selected and proofread by a colleague after the data were transferred to the computer.

As the reliability of the PPAS was not previously established, Cronbach's Alpha test for internal reliability was done on the parents' PPAS scores

following data collection but prior to data analysis. The coefficient Alpha for the parents' group was $r = .86$.

Data Analysis

Analysis of the Demographic Data

Descriptive statistics were run on all data. Tables were utilized to reflect the demographic data in relation to parental participation attitude scores. The following null hypothesis was tested: There is no significant relationship ($p < .05$) among the seven demographic variables, (age, gender, number of children, highest grade achieved in school, employment status, type of employment, and the number of times a child had been hospitalized) and the PPAS scores. This null hypothesis was tested using 1) scatterplots of the seven demographic variables and the PPAS scores to identify if a relationship existed among the variables, and 2) correlational analysis was done using the SPSS-X PC computer program, specifically Pearson r correlations.

Analysis of the Value Orientation Questionnaire

There were three steps in the data analysis of the Value Orientation Questionnaire. The first step used the Kendall S statistic (Kluckhohn and Strodtbeck, 1961) to check for the degree of consensus for all choices given by the parents in all items. This step examined the pattern of responses for all subjects in each value orientation to determine whether the questions were answered by chance or were distinct choices of the respondents.

The second step used binomial analysis to test the strength and direction of the pattern of responses for each item. This analysis answered the question: Between any two of the three alternatives within each orientation, which is preferred to the other? There were three sets of null hypotheses. They were:

"1. alternatives A and B are equally popular;
2. alternatives A and C are equally popular; and
3. alternatives B and C are equally popular"
(Kluckhohn and Strodtbeck, 1961,p. 122-123).

For each of the sets of pairs frequency counts were made of the number of times one alternative was preferred to another. "Preferred to" was defined as:

"For any pair of alternatives A and B, A is preferred to B if (1) A is assigned rank 1, B rank 2; or (2) A is assigned rank 1 and B rank 3; or (3) A is assigned rank 2 and B rank 3" (Kluckhohn & Strodtbeck, 1961, p. 130). These frequencies were then assessed against a normal-curve approximation to a binomial distribution. The following equation was solved to determine the number of people out of n = 37 who preferred one alternative to another in order to reject the null hypotheses that no alternative was preferred to another:

$$z = \frac{fA > B - E(fA > B) - .50}{m\ (pA > B)\ (qB > A)}$$

where
z = a unit of normal deviate
fA>B = the observed frequency of persons preferring A to B
E(fA > B) = the expected frequency of persons prefering A to B
.50 = a correction for continuity
pA > B = the expected proportion of persons preferring A to B
QB > A = the expected proportion of persons preferring B to A
m = the number of persons in the sample

By setting z = 1.96 ($p<.05$ level of significance, two- tailed test) and filling in the known values with 37 respondents, fA > B must be equal to 25 or greater,

or equal to 12 or less in order to reject the null hypothesis. Each question in each value orientation was examined for the pattern of responses and the probability that the pattern did not occur by chance.

The third step in the analysis used the t-test to determine if there was a significant pattern for each value orientation. This step determined whether there was a distinct preference in each orientation and the sequence of the preference for the entire group.

The null hypothesis assumed no difference in the overall preference in each orientation. Paired alternatives were examined for each respondent within each orientation. Scores could range from 0.0 to 7.0 depending on the number of items per orientation. No preference was indicated by halving the potential score. The difference between the expected mean frequency of preferences and the observed mean frequency of preferences was compared by using a t-test. The t-test tested the significance of the preferences. The sign of the t-test indicated the ordering of the preferences. A positive sign indicated that the first alternative was preferred, while a

negative sign indicated that the second alternative was preferred.

These three analyses provided a rank ordering of preferences for each question, and a rank ordering of values for each orientation.

Analysis of the Relationship between the Dominant Value Orientations and the Attitude Scores

The final step in the analysis was performed to test the following null hypothesis:

> There will be no significant correlation between the dominant value orientations and Parental Participation Attitude Scores (PPAS).

Individual parent's rankings in each of the four value orientations were tabulated by using simple tables that included the orientation (Relational, Man-Nature, Time, Activity), the question number, and the ranking of the solutions (see Appendix F). The rankings were tabulated to identify a dominant ranking for every individual parent in each of the four orientations. This involved counting the number of times each of the three solutions (two solutions in the Activity

orientation) in each orientation was chosen as a first-ranked choice. Respondent's value orientations were then analyzed to determine how many times the alternatives within each orientation were chosen as a first-ranked choice. Scores for an individual varied from 0 to 7 depending on the number of questions per orientation. This form of data analysis was pretested on a group of seven individuals from a graduate seminar class. The results of the pretest indicated the ease with which the dominant choice of each value orientation could be distinguished using this particular type of analysis.

The scores for the dominant preference alternatives in the four orientations were then correlated with the respondents' PPAS score to determine if there was a correlation between the first-ranked value orientation and the PPAS score. Prior to doing the Pearson r correlations, a test for a non-linear relationship was performed and none was found to exist.

CHAPTER IV

FINDINGS

The Study examined three distinct aspects of the association between parental participation and value orientations. The findings will be presented in the following manner. First, a description of the sample and a summary of the PPAS scores will be presented, along with a summary of the relationship between the PPAS scores and the demographic variables. Second, a summary of the Value Orientation Questionnaire results will be presented, including age and gender preference similarities and differences. Finally, the results of the PPAS scores will be discussed in relation to the dominant value orientation preferences.

Description of the Sample

The sample of parents who responded to the questionnaire consisted of 37 participants, all of whom had children between the ages of 3 and 5 years. This included 28 females and 9 males. Thirty-five respondents were married. Thirty-one (86%) had post-secondary education. Twenty (55%) were employed as professionals while 10 (27%) were homemakers. The

average age of the group was 35 years. Because of the method used to generate the sample, the participants in the study are not truly representative of the Edmonton population. As well, all of the participants identified themselves as Canadians. This fact changed the independent variable that was orginally intended. The respondents were a homogeneous group and did not reflect the cultural mix found in Edmonton.

Sources referred to earlier in the literature review revealed that the amount of work done outside the home, the number of children at home, and the number of times a child had been hospitalized were variables that were felt to directly influenced the level of parental participation in hospital care. The number of children in the household ranged from 1 to 4, with the average family having 2.33 children. Twenty-seven percent (10) were employed outside the home in part-time positions, and 44% (16) of the parents were employed full-time. Twenty-three parents indicated that their child had never been hospitalized. Nine respondents indicated that their child had been hospitalized once. Three parents stated that their child had been hospitalized twice. Two parents stated

that their child had been hospitalized three times or more. A summary of the demographic data is presented in Table 1 and Table 2.

Relationship Between Demographic Variables and PPAS Scores

A Pearson r correlational analysis was done using the PPAS score as the independent variable and the number of children, level of work outside the home, type of work outside the home, parents age, parents gender and the number of times a child had been hospitalized as the dependent variables. The results failed to reject the null hypothesis, that there was no significant correlation ($p<.05$) among the PPAS scores and each of the demographic variables. Thus, no significant relationship was found amongst the participation attitude scores and the number of children at home, the number of times a child has been hospitalized, the age of the parent, the gender of the parent, the type of work done by the parent, and the extent to which the parents worked outside the home.

TABLE 1

Demographic Characteristics of the Sample.

VARIABLE	NUMBER OF CASES	PERCENTAGE OF TOTAL
GENDER		
Female	29	78%
Male	8	22%
MARITAL STATUS		
Married	36	98%
Divorced	1	2%
Widow	0	0%
Common-Law	0	0%
OCCUPATION		
Homemaker	9	24%
Laborer	5	14%
Professional	21	57%
Other	2	5%
HOSPITALIZATION		
0 Times	23	62%
1 Time	9	25%
2 Times	3	8%
3 or> Times	2	5%
CHILDREN		
1 child	22	59%
2 children	11	30%
3 or > children	4	11%
EMPLOYMENT		
Unemployed	10	28%
Part-time	10	28%
Full-time	16	43%

TABLE 2

Mean Age, Number of Children, and PPAS Score.

VARIABLE	MEAN	STANDARD DEVIATION	MAXIMUM	MINIMUM
Age	35 years	4.74	48	25
Number of Children	2.33	.72	4	1
PPAS	79.72	10.46	99	58

Parental Participation Attitude Scale

The attitude scores were calculated and totalled as follows. Scores for individual items varied from 0-strongly disagree, 1-disagree, 2-neither disagree nor agree, 3-agree, to 4-strongly agree. Each of the individual items for each respondent was totalled to provide an overall attitude score. Similar to the scoring system used in O'Connor Reid's (1984) study, scores greater than 3 indicated a favorable attitude towards the care procedure. Scores between 1.95 and 3.00 indicated parents were unsure of the care procedure and a score below 1.95 indicated that parents

had an unfavorable attitude towards participating in the procedure. Mean scores for each item are provided in Appendix E. Participants who scored 3 or greater in all of the items achieved a score greater than 78 and by definition had a positive attitude towards participation.

The aspects of care that parents found most acceptable (scores greater than 3) included: 1) giving emotional support to a child, 2) being present for the child, 3) accompanying a child to X-ray, 4) helping other parents with their children, 5) bathing and brushing their child's teeth, 6) feeding a child, 7) staying with the child overnight, 8) measuring and recording urine output, 9) restraining a child, 10) giving medications, and 11) taking and recording a child's pulse.

Aspects of care that parents were uncertain about included: 1) noticing a change in skin color, 2) taking a temperature and recording it, 3) changing bandages after instruction by a nurse, 4) being allowed to visit whenever they wish, and 5) knowing whether or not to be with a child. There were no aspects of care that parents felt they did not wish to participate in(see

Appendix E).

Overall Parental Value Orientations

I next examined the value orientations of the parents as a distinct cultural group. As described previously the data were analyzed using three statistical tests. The first step used the Kendall S statistic to check for the degree of consensus for all choices given by the parents to all items. The second step used binomial analysis to test the strength and direction of the pattern of responses for each item. The third step in the analysis used the t-test to determine if there was a significant pattern for each value orientation. This step determined whether there was a distinct preference in each orientation and the sequence of the preference for the entire group. This three-step analysis will be presented, followed by a similar analysis of the subgroup's gender and age.

Kendall S Analysis

Relational orientation. The findings for the total group of parents were that items R1, R3, R4, R6, and R7 (see Appendix A) were significant at the p =.01 or

better. Items R2 and R5 were not significant.

Time orientation. All of the items in the time orientation were significant at the p =.01 or better level, except question T2, which was significant at the p =.05 level.

Activity orientation. Two of the items, A1 and A2, were significant at the p < .01 level. Questions A3 through A6 inclusive were not significant.

Man-Nature orientation. Items MN1, MN2, MN3, and MN5 were significant at the p < .01 level. Question MN 4 was not significant.

Binomial Analysis and the t-Test.

The results of the binomial analysis and the t-test, including the pattern of response for each item and the orientation-ranking preferences are presented in Table 3.

Overall, in the Relational orientation, Collateral was preferred (but not statistically significantly) to Individualistic, which was significantly preferred to Lineal. Overall, in the Time orientation, Present preferred to Future, and Future was preferred to Past. The Time preferences were significant at the p <.05

level. Overall, in the Activity orientation, Doing was preferred to Being. This preference was not significant at the $p < .05$ level. Overall, in the Man Nature orientation Mastery over Nature was preferred to Subjugated to Nature, which was preferred to Harmony with Nature. The Man-Nature preferences were significant at the $p < .05$ level.

TABLE 3

Summary of Parental Value Orientation Rankings.

RELATIONAL	TIME	ACTIVITY	MAN-NATURE
1 Ind>Coll>Lin*	1 Pres>Fut>Past	1 Do>Be	1 Sub≥Over>With
2 Coll≥Ind≥Lin	2 Fut≥Pres>Past	2 Do>Be	2 Sub≥Over=With
3 Ind≥Coll≥Lin	3 Pres≥Fut>Past	3 Do>Be	3 Over>Sub=With
4 Ind≥Coll>Lin	4 Fut>Pres≥Past	4 Be>Do	4 Sub≥With=Over
5 Coll≥Ind≥Lin	5 Fut>Pres≥Past	5 Do≥Be	5 Over>With≥Sub
6 Coll≥Ind>Lin		6 Be>Do	
7 Coll≥Ind>Lin			
SUMMARY	**SUMMARY**	**SUMMARY**	**SUMMARY**
COL≥IND>LIN	PRES>FUT>PAST	DO≥BE	OVER>SUB>WITH

*Key:**A>B>C** (A over B, A over C, and B over C - all preferences are significant at p = .05 or better).

A≥B>C (A over C, and B over C significant at p = .05 level or better; A>B is preferred but not significant).

A>B≥C (A over B, and A over C significant at p = .05 level or better; B over C is preferred but not significant).

A≥B≥C (None of the preferences are statistically significant).

A>B=C (One preference is significantly preferred as the dominant choice; equal preference exists between the other two choices).

Comparison by Gender

The VOQ answers were sorted by gender in order to analyze gender differences. Preferences were recalculated, as the group sizes and samples differed.

Kendall S Analysis - Females

The Relational items R1,R3,R4,R6, and R7 were significant at the $p < .01$ level. Items R2 and R5 were not significant.

In the Time Orientation, items T1,T3,T4, and T5 were significant at the $p < .01$ level. Item T2 was not significant. Activity orientation items A1,A2, and A6 were significant at the $p < .01$ level, while items A3, A4, and A5 were not significant. In the Man-Nature orientation, items MN1,MN3, and MN5 were significant at the $p < .01$ level. Item MN2 was significant at the $p > .05$ level and item MN4 was not significant.

Kendall S Analysis - Males

In the Relational orientation, items R1, R3, R4, R6, and R7 were significant at the $p < .01$ level. Items R2 and R5 were not significant. In the Time orientation items T1, T2, T3, and T5 were significant at the $p < .01$

level. Item T4 was not significant. In the Activity orientation, none of the items were significant. In the Man-Nature orientation, items MN1 and MN3 were significant at the $p < .05$ level while items MN2, MN4, and MN5 were not significant.

Binomial Analysis & t-Test - Males and Females

Females ($n = 29$) indicated a preference, albeit not statistically significant, in the Relational orientation for Individualistic $\geq$ Collateral > Lineal whereas males ($n = 8$) preferred Collateral $\geq$ Individualistic $\geq$ Lineal similar to the preference of the total parents group.

The Time preference ranking for the females was Present > Future > Past, similar to the total group patterning.

The Activity preference for the males was again similar to the total group pattern of Doing over Being. The female Activity preference was Being $\geq$ Doing. Summaries of the binomial analysis and the t-test findings are presented in Tables 4 & 5.

TABLE 4

Female Value Orientations

RELATIONAL	TIME	MAN NATURE	ACTIVITY
1 Ind>Coll>Lin	1 Pres>Fut>Past	1 Subj>Over>With	1 Do> Be
2 Coll≥Ind≥Lin	2 Fut≥Pres>Past	2 Over=Subj>With	2 Do> Be
3 Coll≥Ind≥Lin	3 Fut≥Pres>Past	3 Over>Subj=With	3 Do> Be
4 Ind≥Coll>Lin	4 Pres>Fut>Past	4 Over≥Subj=With	4 Do> Be
5 Coll≥Ind>Lin	5 Fut≥Pres≥Past	5 Over>With>Subj	5 Do≥ Be
6 Coll≥Ind>Lin			6 Be> Do
7 Coll≥Ind>Lin			
SUMMARY	**SUMMARY**	**SUMMARY**	**SUMMARY**
IND≥COLL>LIN	PRES>FUT>PAST	OVER>SUBJ≥WITH	DOING>BEING

Key: p. 56

TABLE 5

Male Value Orientations

RELATIONAL	TIME	MAN NATURE	ACTIVITY
1 Ind=Coll≥Lin	1 Pres>Fut>Past	1 Over>Subj>With	1 Do ≥Be
2 Coll≥Lin>Ind	2 Fut>Pres≥Past	2 Over≥Subj>With	2 Do ≥Be
3 Ind≥Coll>Lin	3 Pres>Fut>Past	3 Over>Subj=With	3 Do =Be
4 Ind=Coll>Lin	4 Fut≥Pres≥Past	4 With>Over≥Subj	4 Be >Do
5 Coll≥Ind≥Lin	5 Fut≥Pres≥Past	5 Over>Subj=With	5 Do =Be
6 Coll≥Ind>Lin			6 Be >Do
7 Coll=Ind>Lin			
SUMMARY	**SUMMARY**	**SUMMARY**	**SUMMARY**
COLL≥IND≥LIN	FUT≥PRES>PAST	OVER>SUBJ≥WITH	BEING≥DOING

Key: p. 56

Comparison by Age

The VOQ answers were sorted by age to analyze the differences. The two groups included respondents under 35 (n = 15), and respondents 35 years of age or older (n = 22). Calculations were recalculated as the group

sizes and samples differed. Summaries of the findings are presented in Tables 6 and 7.

Kendall S Analysis - Under 35 Years

In the Relational orientation, items R1, R4, and R6 were significant at the $p < .01$ level. Items R2, R3, and R5 were not significant. In the Time orientation, T1, T3, and T4 were significant at the $p < .01$ level. Items T2 and T5 were not significant. In the Activity orientation, A1 and A2 were significant at the $p < .01$ level, while item A6 was significant at the $p < .05$ level. Items A3, A4, and A5 were not significant. In the Man-Nature orientation, items MN1, MN3, and MN5 were significant at the $p < .01$ level. Items MN2 and MN4 were not significant.

TABLE 6

Value Orientations of Parents under 35 Years of Age

RELATIONAL	TIME	MAN NATURE	ACTIVITY
1 Coll>Ind>Lin	1 Pres>Fut>Past	1 Subj≥Over>With	1 Do> Be
2 Coll≥Ind≥Lin	2 Fut≥Pres≥Past	2 Subj≥Over>With	2 Do> Be
3 Coll>Ind≥Lin	3 Pres≥Fut>Past	3 With≥Over>Subj	3 Do> Be
4 Coll≥Ind>Lin	4 Pres≥Fut>Past	4 Over≥Subj≥With	4 Be≥ Do
5 Lin≥Ind=Coll	5 Fut≥Pres≥Past	5 Over>Subj≥With	5 Do> Be
6 Coll≥Ind>Lin			6 Be> Do
7 Coll>Ind>Lin			
SUMMARY	**SUMMARY**	**SUMMARY**	**SUMMARY**
COLL>IND>LIN	PRES>FUT>PAST	OVER>SUBJ>WITH	DOING>BEING

Key: p. 56

Kendall S Analysis - 35 Years and Over

In the Relational orientation, items R1, R4, R5, R6, and R7 were significant at the $p < .01$ level. Items R2 and R3 were not significant. In the Time orientation, T1, T3, T4, and T5 were significant at the $p < .01$ level. Item T2 was significant at the $p < .05$

level. In the Activity orientation none of the items were significant. In the Man-Nature orientation all of the items were significant at the p <.01 level.

TABLE 7

Value Orientations of Parents 35 Years of Age & Over

RELATIONAL	TIME	MAN-NATURE	ACTIVITY
1 Ind≥Coll>Lin	1 Pres>Fut>Past	1 Subj≥Over>With	1 Do> Be
2 Coll>Lin≥Ind	2 Fut≥Pres>Past	2 Over=Subj≥With	2 Do> Be
3 Ind≥Coll>Lin	3 Pres≥Fut>Past	3 Over>Subj≥With	3 Do> Be
4 Coll≥Ind>Lin	4 Pres≥Fut>Past	4 Subj=Over≥With	4 Be> Do
5 Coll>Ind>Lin	5 Fut>Pres≥Past	5 Over>Subj=With	5 Do≥ Be
6 Coll=Ind>Lin			6 Be> Do
7 Coll≥Ind>Lin			
SUMMARY	**SUMMARY**	**SUMMARY**	**SUMMARY**
IND≥COLL>LIN	PRES>FUT>PAST	OVER≥SUBJ≥WITH	DO≥BEING

Key: p. 56

Binomial Ananlysis & t-Test for both Age Groups

The Relational preference for the under 35 years age group was Collateral ≥ Individualistic > Lineal whereas the Relational preference for the 35 years and

over age group was Individualistic ≥ Collateral > Lineal. The three remaining Orientations, Time, Man-Nature, and Activity, were similar for both age groups.

Seven of the eight male respondents fell into the 35 years and over age group. In comparing the age preferences to the gender preferences, results indicated that the preferences of the 35 years and over group (including eight of the nine males) were similar to the female preferences in each of the orientations. The males in the 35 and over age group therefore do not skew the data. In this sample, age plays a more meaningful role than gender differences.

Parental Participation Attitude Scores and Dominant Value Orientation Preferences

The results of the value orientation analysis yielded noticeable results that may warrant future investigation. For example, the parents in this study significantly preferred the Present over the Future and the Future over the Past in the time orientation. This preference was similar to the Time preference of the female group and interestingly different from the male Time preference, which was Future over Present and

Present over Past. As well, the under 35 years group preferred Collateral over Individualistic over Lineal in the Relational orientation, whereas the 35 years and over age group preferred, though not significantly, Individualistic over Collateral over Lineal. The overall results of the age subgroups would lead one to speculate that age plays an important part in determining parents' value orientation.

Relationship Between Dominant Value Orientations and PPAS Scores

The final stage of the analysis included conducting Pearson r correlations between the dominant value orientation preferences and the parental participation attitude scores. Participants' dominant preferences for each item in each orientation were totalled. This involved counting the number of times each of the three solutions (two solutions in the Activity orientation) in every orientation was chosen as a first-ranked choice. Participants were given a total score for each of the three preferences in every orientation. For example, if participant 01 chose the

Future as the dominant preference in the Time orientation three times, the Present two times and the Past 0 times, he or she received scores of 3, 2, 0 for dominant Future, Present, and Past preferences. All of the participants were scored in this manner to yield a table that included first-choice scores for every alternative in each orientation as well as PPAS scores. Respondents dominant choice scores were correlated with the participants' PPAS scores. This was done to ascertain if there was a relationship between the parental participation attitude scores and the first-ranked value orientation choice. As well correlations were done between each of the value orientation alternatives.

The following null hypothesis was tested:

> "There will be no significant correlation between the dominant value orientations and Parental Participation Attitude Scale (PPAS) scores."

Results demonstrated a positive correlation

between the Individualistic Relational orientation and the attitude score at the p <.05 level. (see Table 8). Parents who choose individualistic as the dominant relational preference are more likely to prefer making decisions independently. They also prefer to act independently. For example, in vignette 12 (Appendix A), respondents who chose the alternative of being one's own boss and acting independently are recorded as individualistic in nature.

An example of the collateral alternative in vignette 12, involved shared resposibility of all individuals in the work group. In the lineal alternative, one individual is selected as the owner or boss who makes all the decisions. Neither the Collateral nor the Lineal alternatives correlated significantly with the PPAS scores.

Results demonstrated a negative correlation between the Past Time orientation and the attitude score at the p <.05 level. Parents who choose Past as the dominant time orientation base their actions on the ways of the past. For example in vignette 11 (Appendix A), respondents whose dominant preference is the Past believe the best philosophy for living one's life is to

observe the ways of the past. In the Present alternative the past is gone and the future is uncertain therefore it is best to pay attention to what is happening in the present. The Future alternative states that the ways of the future are always best. Present orientation and the Future orientation did not correlate significantly with the PPAS scores (see Table 8.)

Correlational analysis was done to determine if there was a significant intercorrelation between a dominant Individualistic relational orientation, and a dominant Past time orientation. Due to the fact that the intercorrelation was not significant at the $p<.05$ level, a multiple regression analysis was not warranted.

Results of the correlations among the Man-Nature orientation solutions, the Activity orientation solutions, and the Attitude scores were not significant at the $p <.05$ level.

The findings of this study can be summarized as follows. First, the parents in this study had positive attitudes towards participating in the hospital care of their preschool child.

Second, the parents as a group had significant ($p<.05$) value orientation preferences in the Time and Man-Nature orientations. In the Relational orientation, Collateral was preferred to Individualistic, albeit not significantly ($p<.05$). Individualistic was preferred to Lineal. The Present was preferred over the Future, which was preferred over the Past in the Time orientation. In the Man-Nature orientation, Mastery over Nature was preferred to Subjected to Nature, which in turn was preferred to Harmony with Nature. Doing was preferred to Being in the Activity orientation although this preference was not significant at the $p<.05$ level.

Finally, there was a significant positive relationship between the Individualistic alternative when chosen as the dominant Relational preference and the parental attitude towards participation ($p<.05$). As well, there was a significant negative correlation between the Past alternative when chosen as the dominant Time preference and the parental attitude towards participation ($p<.05$).

TABLE 8

Correlations between Parents' PPAS Score and Dominant Value Orientations

ORIENTATION	CORRELATION	LEVEL OF SIGNIFICANCE
ACTIVITY		
Doing	-.0267	P=.438
Being	+.0420	P=.405
RELATIONAL		
Individualistic	+.3023	P=.034*
Collateral	-.2304	P=.085
Lineal	-.1188	P=.245
TIME		
Past	-.2984	P=.036*
Present	+.0578	P=.367
Future	+.0803	P=.318
MAN-NATURE		
Over	-.0974	P=.283
With	+.1260	P=.229
Subjected to	+0118	P=.472

*p<.05

CHAPTER V

CONCLUSIONS

Research into parental participation in the care of hospitalized children was active in the late 1960s and the early 1970s. Following the introduction of Care by Parent Units, research waned throughout the late 1970s. The advancement of Family-Centered-Care and the reduction in health care resources served to rekindle interest in discovering more regarding parental participation. In particular, researchers became interested in the characteristics that influenced the amount parents participated in the care of a hospitalized child.

Paediatric researchers are presently not aware of significant factors that contribute to the amount that parents participate in their child's hospital care. Past research in parental participation has attempted to list the activities parents were capable of doing. This did not get at the reasons why parents participated. In recognizing that the lack of participation was unique to North Americans, Bell and Bell (1970) revealed a culturally based value that may be responsible for the differing levels of

participation. Knowing the values underlying parents' attitudes towards participation is essential in understanding why parents participate or do not participate in a child's hospital care. The purpose of this study was to answer the question, "Is there a relationship between value orientations and attitudes towards participation in the care of a hospitalized child among parents of preschool children in Edmonton?"

Thirty-seven parents of preschool-aged children in Edmonton were the sample for this study. This included 29 women and 8 men. The parents were between 25 and 48 years of age. One respondent indicated that they were divorced with the remaining 36 being married. Eighty questionnaires were sent to individuals known to have children between the ages of 3 and 5 years of age. Respondents completed a questionnaire that included the Value Orientation Questionnaire (Kluckhohn & Strodtbeck, 1961), the Parental Participation Attitude Scale (PPAS), and a demographic data questionnaire.

Descriptive statistics were run on all data. Correlational analysis was done using the SPSS-X PC computer program, specifically the Pearson r correlations, on the parents' attitude scores and the

demographic data. Analysis of the Value Orientation Questionnaire provided dominant value preferences for each respondent, which were then correlated with the respondents' PPAS score to determine if there was a correlation between the first-ranked value orientation and attitudes towards participation.

The results of the analysis demonstrated that there was a significant relationship between Individualistic as the dominant Relational value orientation and a positive attitude towards parental participation. As well, a significant relationship between choosing Past as the dominant Time value orientation and negative attitudes towards participation was established. The PPAS also was useful in determining the activities parents viewed positively and to participate in.

Findings compared to Other Parental Participation Research

Respondents had a positive attitude towards participation. These results corroborate the findings of Beck (1973), Hill (1978), and O'Connor Reid (1984),

which all concluded that parents showed positive attitudes towards participating in the hospital care of their child. Specifically, parents wished to be physically present with their hospitalized child, providing emotional support and assisting them in the activities of daily living.

Similar to Beck and O'Connor Reid's findings, no significant relationship was found between parents' personal characteristics, including age, years of education, and number of children at home, and the PPAS scores. Findings in this study were also not able to demonstrate a significant difference in the attitude scores of those parents who had previous experience and those without previous hospitalization experience, whereas Knafl et al. (1988) indicated that such a relationship existed.

The PPAS instrument has been used in several studies to demonstrate areas of hospital care in which parents wish to participate. In this study, coefficient Alpha was used to estimate the reliability of the PPAS instrument. The parent group yielded an Alpha of .87. To date, this is the highest reliability coefficient achieved. The PPAS was a reliable tool for determining

in which activities parents of hospitalized children wished to participate.

Relevance to Parental Participation Research

The hospitalization of a child is a stressful event even when it is planned. As a result, communication between health care workers and parents is often misunderstood and/or misinterpreted. Research indicates (Knafl et al., 1988, O'Connor Reid, 1984) that both nurses and parents struggle with the identification of their unique roles in the care of the hospitalized child. This study has demonstrated there is a significant relationship between the dominant Relational and Time value orientations and parental attitudes towards participation. The study also revealed that one limitation of using the Value Orientation Questionnaire along with the PPAS is that the combined length of the two tools produced a questionnaire that was lengthy and time-consuming for parents to complete. By using the questions in the VOQ that pertain to the Relational and Time orientations, one would substantially reduce the length of the questionnaire. The revised questionnaire (including the

Relational and Time questions and the PPAS) would be an efficient method of determining on admission to hospital both which parents had positive attitudes towards participating and activities in which they wished to participate. For example, if a parent had an individualistic dominant relational preference, a nurse would be able to identify that he or she may want to participate in their child's care. As well, if a parent had a dominant past time orientation, a nurse would be able to appreciate that he or she may not want to participate in their child's care. These findings would be instrumental in the development of a family-centered plan of care.

Findings Compared with Other Value Orientation Literature

There have been numerous studies of value orientations of various cultural groups throughout the years. The findings in the study differ from Kluckhohn's and Stodtbeck's (1961) core American dominant orientation preferences in the Relational, Time, and Man-Nature orientations.

DeMay's (1982) findings on the American Army personnel

were similar in the Time orientation and the first-choice Man-Nature orientation.

Papajohn and Spiegel's (1975) findings on three families from three cultural groups (Greek, Italian and Puerto Rican) were similar to this study's parent group only in the dominant Time orientation. All the groups chose the Present as the first-choice Time orientation.

Caudill and Scarr's (1962) study of Japanese people and this study's parent group were similar in the first choice in the Man-Nature orientation (Over) and the Relational (Collateral) orientation.

There was only one similar dominant choice between Tripp-Reimer and Friedl's (1977) study of Appalachian Americans and this study's parent group. Both groups chose the Present as the dominant Time orientation. Egeland's (1978) study of five groups of residents in Miami (Bahamian, Cuban, Haitian, Puerto Rican, and Southern Black) demonstrated a similar dominant Time orientation to this study's parent group. Brink's (1984) study of the Annang compared exactly (similar first, second, and third choices) with this study's parent group for the Relational and Time orientations.

Ogden Burke and Maloney (1986) studied women's

value orientations by using an adapted version of the original VOQ. The women in this study's parent group made the same choices as the nurses and the Euro-Canadian women in the Ogden Burke and Maloney study in the Relational, Time, and Activity orientations. Gushuliak (1990) studied Hutterian women in Canada. The women in this study's parent group had similar first choices to the Hutterian women in the Time and Activity orientations.

Relevance to Value Orientation Research

Use of the Value Orientation Questionnaire to test a group of parents adds to the literature on value orientations by providing data on a group of Canadian adults. Further research is required to develop a Canadian value orientation profile. Canadians have long recognized a cultural difference between themselves and Americans. Value orientation research on Canadian samples is one method of quantifiably defining the core Canadian value orientations. Health care providers will then be able to give Canadians care that is grounded in a recognized set of values.

Implication for Nurses

Nurses who work with paediatric populations nurse not only the child in hospital but the entire family of the child as well. Recognizing the family's need to be involved in the hospital care is one of the first steps towards providing effective family-centered health care. Assessing if and how parents wish to be involved in their child's care is the responsibility of care givers on admission of the child to the hospital.

This study has demonstrated that combining a modified VOQ with the PPAS may yield a valuable tool for nurses to use in determining parental levels of participation. As well, use of the tool would provide nurses with specific activities parents wished to perform, consequently identifying and delimiting the nurses' and the parents' roles.

Recommendations for Further Study

Studies should be done to test further the revised tool (a questionnaire including the Relational and Time questions from the VOQ and the PPAS) to determine if

the identified relationships hold true. The identification, of parents likely to participate, based on dominant value preferences, will provide paediatric caregivers with valuable insight into the families with whom they interact with. Further value orientation research is also warranted, particularly with Canadian populations. Knowledge of cultural value preferences is essential if health care providers wish to understand and assist individuals in becoming actively involved in their own health care.

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Appendix A.

VALUE ORIENTATION QUESTIONNAIRE

1.Job Choice A1,A2

A man needed a job and had a chance to work for two men. The two bosses were different. Listen to what they were like and say which one you think would be the best one to work for.

D.One boss was a fair enough man, and he gave somewhat higher pay than most men, but he was the kind of boss that insisted that men work hard, stick on the job. He did not like it at all when a worker sometimes knocked off work for a while to go on a trip or to have a day off or so to have fun, and he thought it was right not to take such a worker back on the job.

B.The other paid just average wages but he was not so firm. He understood that a worker would sometimes just not turn up-would be off on a trip or having a little fun for a day or two. When his men did this he would take them back without saying too much.

(Part one)

Which of these men do you believe it would be better to work for in most cases?_____

Which of these men would most others think it better to work for?_____

(Part two)

Which kind of boss do you believe that it is better to be in most cases?_____

Which kind of boss would others think it better to be?_____

2.Well Arrangements R1

When a community has to make arrangements for water, such as drill a well, there are three different ways they can decide to arrange things like location, and who is going to do the work.

L.There are some communities where it is mainly the older or recognized leaders of the important families who decide the plans. Everyone usually accepts what they say without much discussion since they are the ones who are used to
deciding such things and are the ones who have the most experience.

C. There are some communities where most people in the group have a part in making the plans. Lots of different people talk, but nothing is done until almost everyone comes to agree as to what is best to be done.

I.There are some communities where everyone holds to his own opinion and they decide the matter by vote.

They do what the largest number want even though there are still a very great many people who disagree and object to the action.

Which way do you think is usually best in such cases?_____
Which of the other two ways do you think is better?_____
Which way of all three do you think most other persons would usually think is best?_____

3.Child Training T1

Some people were talking about the way children should be brought up. Here are three different ideas.

PA. Some people say that children should always be taught well the traditions of the past (the ways of the old people). They believe the old ways are best, and that it is when children do not follow them too much that things go wrong.

PR. Some people say that children should be taught some of the old traditions (ways of the old people), but it is wrong to insist that they stick to these ways. These people believe that it is necessary for children always to learn about and take on whatever the new ways will

best help them get a long in the world today.

F. Some people do not believe children should be taught much about past traditions (the ways of the old people) at all except as an interesting story of what has gone on. These people believe that the world goes along best when children are taught the things that make them want to find out for themselves new ways of doing things to replace the old.

Which of these people had the best idea about how children should be taught?_____
Which of the other two had the better idea?

Considering again all three ideas, which would most other people say had the better idea? _____ _

4. Livestock Dying MN1

One time a man had a lot of livestock. Most of them died off in different ways. People talked about this and said different things.

S. Some people said you just can't blame a man when things like this happen. There are so many things that can and do happen, and a man can do almost nothing to prevent such losses when they come. We all have to learn to take the bad with the good.

O. Some people said that it was probably the man's own fault that he lost so many. He probably didn't uses his head to prevent the losses. They said that it's usually the case that men who keep up on new ways of doing things, and really set themselves to it, almost always find a way to keep out of such trouble.

W. Some people said that it was probably because the man had not lived his life right - had not done things the right way to keep in harmony between himself and the forces of nature (i.e., the ways of nature like the rain, winds, snows,etc.).

Which of these reasons do you think is most usually true ? _____
Which of the other two reasons do you think is more true ? _____
Which of all three reasons would most other people think is usually true ? _____

5. Expectations about change T2

(a. 20 - 40 age group)

Three young people were talking about what they thought their families would have one day as compared with their fathers and mothers. They each said different things.

F. The first said: I expect my family to be better off in the future than the family of my father and mother or relatives if we work hard and plan right. Things in this country usually get better for people who really try.

PR. The second one said: I don't know whether my family will be better off, the same or worse off than the family of my father and mother or relatives. Things always go up and down even if people do work hard. So one can never really tell how things will be.

PA. The third one said: I expect my family to be about the same as that family of my father and mother or relatives. The best way is to work hard and plan ways to keep up things as they have been in the past.

Which of these people do you think had the best idea ?

_____

Which of the other two persons had the better idea ?

_____

Which of these three people would most others your age think had the best idea ?

_____

(b. 40-up Age group)

Three older people were talking about what they thought their children would have when they were grown. Here is what each one said.

F. One said : I really expect my children to have more than I have had if they work hard and plan right. There are always good chances for people who try.

PR. The second one said: I don't know whether my children will be better off, worse off, or just the same. Things always go up and down even if one works hard, so we can't really tell.

PA. The third one said: I expect my children to have just about the same as I have had or bring things back as they once were. It is their job to work hard and find ways to keep things going as they have been in the past.

Which of these people do you think had the best idea ?

_____

Which of the other two persons had the better idea ?

_____

Which of these three people would most others your age think had the best idea ?

_____

6. Facing Conditions MN2

There are many different ways of thinking about how God (the gods) is (are) related to man and to the weather and all other natural conditions which make the crops and animals live or die. Here are three possible

ways.

W. God (the gods) and people all work together all the time; whether the conditions which make the crops and animals grow are good or bad depends upon whether people themselves do all the proper things to keep themselves in harmony with their God (gods) and with the forces of nature.

O. God (the gods) does (do) not directly use his (their) power to control all the conditions which affect the growth of crops or animals. It is up to the people themselves to figure out the ways of controlling them.

S. Just how God (the gods) will use his (their) power over all the conditions which affect the growth of crops and animals cannot be known by man. But it is useless for people to think they can change conditions very much for very long. The best way is to take conditions as they come and do as well as one can.

Which of these ways of looking at things do you think is best ? _____

Which of the other two ways do you think is better ? _____

Which of the three ways of looking at things would most other people think best ? _____

7. Help in Misfortune R2

A man had a crop failure, or, let us say, had lost some of his sheep or cattle. He and his family had to have help from someone if they were going to get through the winter. There are three different ways of getting help. Which of these three ways would be best ?

C. Would it be best if he depended mostly on his brothers and sisters or other relatives all to help him out as much as each one could ?

I. Would it be best for him to try to raise the money on his own outside the community (his own people) from people who are neither relatives nor employers ?

L. Would it be best for him to go to a boss or older important relative who is used to managing things in his group, and ask him to help out until things get better ?

Which way of getting help do you think would usually be best ?

_____

Which way of getting help do you think is the next best ?

_____

Which way do you think you yourself would really follow ?

_____

Which way do you think most other

people would think best ?

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8. Family Work Relations R3

I'm going to tell you about three different ways families can arrange work. These families are related and they live close together.

C. In some groups (or communities) it is usually expected that each of the separate families (by which we mean just husband, wife, and children) will look after its own business separate from all others and not be responsible for the others.

L. In some groups (or communities) it is usually expected that the close relatives in the families will work together and talk over among themselves the way to take care of whatever problems come up. When a boss is needed they usually choose (get) one person, not necessarily the oldest able person to manage things.

I. In some groups (or communities) it is usually expected that the families which are closely related to each other will work together and have the oldest able person (hermano, mayor or father) be responsible for and take charge of most important things.

Which of these ways do you think is usually best in most cases ?

_____

Which of the other two ways do you think is better ?

_____

Which of all the ways do you think most other persons would think is usually the best ?

_____

9. Choice of Delegate R4

A group like yours (community like yours) is to send a delegate - a representative - to a meeting away from here (this can be any sort of meeting) How will the delegate be chosen ?

C. Is it best that a meeting be called and everyone discuss things until almost everyone agrees so that when a vote is taken almost all people would be agreed on the same person ?

L. Is it best that the older, important, leaders take the main responsibility for deciding who should represent the people since they are the ones who have had the long experience in such matters ?

I. Is it best that a meeting be called, names be put up, a vote be taken, then send the man who gets the

majority of votes even if these are many people who are still against this man?

Which of these ways of choosing is usually best in cases like this ?

_____

Which of the other two ways is usually better ?

_____

Which would most other persons say is usually best ?

_____

10. Use of Fields MN3

There were three men who had fields with crops (were farmers). The three men had quite different ways of planting and taking care of the crops.

W. One man put in his crops, worked hard, and also set himself to living in right and proper ways. He felt that it is the way a man works and tries to keep himself in harmony with the forces of nature that has the most effect on conditions and the way crops turn out.

S. One man put in his crops. Afterwards he worked on them sufficiently but did not do more than was necessary to keep them going along. He felt that is mainly depended on weather conditions how they would turn out, and that nothing extra that people do could

change things much.

O. One man put in his crops and then worked on them a lot of the time and made use of all the new scientific ideas he could find out about. He felt that by doing this he would in most years prevent many of the effects of bad conditions.

Which of these ways do you believe usually best ?

_____

Which of the other two ways do you believe is better ?

_____

Which of the three other ways would most other persons think is best ?

_____

11. Philosophy of Life T3

People often have different ideas about what has gone before and what we can expect in life. Here are three ways of thinking about these things.

PR. Some people believe it is best to give most attention to what is happening now in the present. They say that the past has gone and the future is much too uncertain to count on. Things do change, but it is sometimes for the better and sometimes for the worse,

so in the long run it is about the same. These people believe that the best way to live is to keep those of the old ways that one can - or that one likes - but to be ready to accept the new ways which will help to make life easier and better as we live from year to year.

PA. Some people think that the ways of the past (ways of the old people or traditional ways) were the most right and the best, and when changes come things get worse. These people think the best way to live is to work hard to keep to the old ways and try to bring them back when they are lost.

F. Some people believe that it is almost always the ways of the future - the ways which are still to come - which will be best and they say that even though there are sometimes small setbacks, change brings improvements in the long run. These people think the best way to live is to look a long time ahead, work hard, and give up many things now so that the future will be better.

Which of these ways of looking at life do you think is best ? _____

Which of the other two do you think is better ? _____

Which of the three ways of looking at life do you think most people would think is best ? _____

12. Wage Work R5

There are three ways which men who do not themselves hire others may work.

I. One way is working on one's own as an individual. In this case a man is pretty much his own boss. He decides most things himself, and how he gets along in his own business. He only has to take care of himself and he doesn't expect others to look out for him.

C. One way is working in a group of men where all the men work together without there being one main boss. Every man had something to say in the decisions that are made and all the men can count on each other.

L. One way is working for an owner, a big boss, or a man who has been running things for a long time. (a patron). In this case, the men do not take part in deciding how the business will be run, but they know they can depend on the boss to help them out in many ways.

Which of these ways is usually best for a man who does not hire others ? _____

Which of the two ways is better for a man who does not hire others? _____

Which of the three ways do you think most other persons would think is best? _____

13. Belief in Control MN4

Three men from different areas were talking about the things that control the weather and other conditions. Here is what they each said.

S. One man said: My people have never controlled the rain ,wind and other natural conditions and probably never will. There have always been good years and bad years. That is the way it is, and if you are wise you will take it as it comes and do the best you can.

O. The second man said: My people believe that it is man's job to find ways to overcome weather and other conditions just as they overcome so many things. They believe they will one day succeed in doing this and may even overcome drought and floods.

W. The third man said: My people help conditions and keep things going by working to keep in close touch with all the forces which make the rain, the snow, and other conditions. It is when all that we have - the land, the stock, and the water - is in good condition, that all goes well.

Which of these men do you think had the best idea ? _____

Which of the other two men do you think had the better idea ? _____

Which of the three men do you think most other persons would think had the

best idea ? _____

14. Ceremonial Innovation T4

Some people in a community like your own saw the religious ceremonies (the church services) were changing from what they used to be.

F. Some people were really pleased because of the changes in religious ceremonies. They felt that new ways are usually better than old ones, and they like to keep everything - even ceremonies- moving ahead.

PA. Some people were unhappy because of the change. They felt that religious ceremonies should be kept exactly - in every way - as they had been in the past.

PR. Some people felt that the old ways for religious ceremonies were best but you just can't hang on to them. It makes life easier just to accept some changes as they come along.

Which of these three said most nearly what you would believe is right ?

_____

Which of the other two do you think is more right ?

_____

Which of the three would most others say was most right ?

_____

15. Ways of Living A3

There were two people talking about how they liked to live. They had different ideas.

D. One said: What I care most about is accomplishing things - getting things done just as well or better than other people do them. I like to see results and think they are worth working for.

B The other said: What I care most about is to be left alone to think and act in the way that best suit the way I really am. If I don't always get much done but can enjoy life as I go along, that is the best way.

Which of these two persons do you think has the better way of thinking ?

_____

Which of the two do you think you are more like ?

_____

Which do you think most others would say had the better way of living.

_____

16. Livestock Inheritance. R6

Some sons and daughters have been left some livestock (sheep or cattle) by a father or mother who

has died. All these sons and daughters are grown up, and they live near each other. There are three different ways they can run the livestock.

L. In some groups of people it is usually expected that the oldest able person will take charge of or manage, all the stock held by himself and the other sons and daughters.

I. In some groups of people it is usually expected that each of the sons and daughters will prefer to take his or her own share of the stock and run his or her own business completely separate from all the others.

C. In some groups of people it is usually expected that all the sons and daughters will keep their cattle and sheep together and work together and decide among themselves who is best able to take charge of things, not necessarily the oldest when a boss is needed.

Which of these ways do you think is usually best in most cases ?

_____

Which of the other two ways do you think is better ?

_____

Which of all three ways do you think most other persons would think is usually best ?

_____

17. Land Inheritance R7

Now I want to ask a similar question concerning farm and grazing land instead of livestock.

Some sons and daughters have been left some farm and grazing land by a father or mother who has died. All these sons and daughters are grown and live near each other. There are three ways they can handle the property.

L. In some groups of people it is usually expected that the oldest able person will take charge of, or manage the land for himself and all the other sons and daughters, even if they all share it.

I. In some groups of people it is usually expected that each son and daughter will take his own share of the land and do with it what he wants - separate from all the others.

C. In some groups of people it is usually expected that all the sons and daughters will make use of the land together. When a boss is needed, they all get together and agree to choose someone of the group, not necessarily the oldest, to take charge of things.

Which of these ways do you think is usually best in most cases ?

_____

Which of the other two ways do you think is better ?

_____

Which of all three ways do you think
most other persons would think
is usually best ? _____

18. Care of Fields A4

There were two men, both farmers (men with fields). They live differently.

B. One man kept the crops growing all right but didn't work on them more than he had to. He wanted to have extra time to visit with friends, go on trips, and enjoy life. This was the way he liked best.

D. One man liked to work with his fields and was always putting in extra time keeping them clean of weeds and in fine condition. Because he did this extra work, he did not have much time left to be with friends, to go on trips, or to enjoy himself in other ways. But this was the way he really liked best.

Which kind of man do you believe it
is better to be ? _____

(For men only): Which kind of man
are you really most like ? _____
Which kind of man would most others

think it better to be ? _____

19. Length of Life MN5

Three men were talking about whether people themselves can do anything to make the lives of men and women longer. Here is what each said.

O. One said: It is already true that people like doctors and others are finding the way to add many years to the lives of most men by discovering (finding) new medicines, by studying foods, and doing other such things as vaccinations. If people will pay attention to all these new things they will almost always live longer.

S. The second one said: I really do not believe that there is much human beings themselves can do to make the lives of men and women longer. It is my belief that every person has a set time to live, and when that time comes it just comes.

W. The third one said: I believe that there is a plan to life which works to keep all living things moving together, and if a man will learn to live his whole life in accord with that plan, he will live longer than other men.

Which of these three said most nearly what you would think is right ?

_____

Which of the other two is more right ?

_____

Which of the three would most other persons say was most right ?

_____

20. Water Allocation T5

The government is going to help a community like yours to get more water by redrilling and cleaning out a community well. The government officials suggest that the community should have a plan for dividing the extra water, but don't say what kind of plan. Since the amount of extra water that may come in is not known, people feel differently about planning.

PA. Some say that whatever water comes in should be divided just about like water in the past always was divided.

F. Others want to work out a really good plan ahead of time for dividing whatever water comes in.

PR. Still others want to just wait until the water comes in before deciding on how it will be divided.

Which of these ways do you think is usually the best in cases like this ?

_____

Which of the other two ways do you think is better ?

_____

Which of the three ways do you think most other persons would think best ?

_____

21. Housework A5

There were two women talking about the way they like to live.

B. One said that she was willing to work as hard as the average, but that she didn't like to spend a lot of time doing the kind of extra things in her house or taking up extra things outside like ___. Instead she liked to have time free to enjoy visiting with people - to go on trips - or to just talk with whoever was around.

D. The other said she liked best of all to find extra things to work on which would interest her - for example - She said she was happiest when kept busy and was getting things done.

Which of these ways do you think it is usually better for women to live ?

_____

(For women only):
Which woman are you really more like ?

_____

Which way of life would most others think is best ?

_____

22. Notworking Time A6

Two men spend their time in different ways when they have no work to do (This means when they are not actually on the job)

D. One man spends most of this time learning or trying out things which will help him in his work.
B. One man spends most of this time talking, telling stories, singing, and so on with his friends.

Which of these men has the better way of living ?

_____

Which of these men do you think you are more like ?

_____

Which of these men would most others think had the better way of living ?

_____

Appendix B.

PARENTAL PARTICIPATION ATTITUDE SCALE

Please circle the response that best describes your attitude towards the statements given below. The possible responses are: SD-strongly disagree, d-disagree, N- neither disagree or agree, a- agree, and SA-strongly agree. Please note that in some items the order of the responses are reversed.

1. If a given procedure or treatment is explained to a parent in a clear and understanding manner, the parent will be better able to give the child the emotional support he needs.

SD d N a SA

2. The presence of a child's parent is usually comforting to him.

SD d N a SA

3. When a mother volunteers to feed a child other than her own and permission for such has been granted by the natural mother of the child, she should be allowed to do so provided such action is not medically contradicted.

SD d N a SA

4. Parents should be allowed to help their child bathe and brush his teeth or do things for him.

SD d N a SA

5. It is usually a good practice for parents to accompany their child to X-ray.

SD d N a SA

6. It is better for a mother to feed her own baby or child than it is for the nurse to do so, provided it is not medically contraindicated.

SD d N a SA

7. The relationship between the nurse and the child is improved by having the parent help with the child's hospital care.

SD d N a SA

8. Parents can notice a change in the skin color of their child and report this to the nurse.

SD d N a SA

9. If a mother is involved in the care of her very ill child, then she would usually have an easier time adjusting to the child's death should the child happen to die.

SD d N a SA

10. Generally, parents should not accompany their children to the X-ray room even after having observed the necessary precautions.

SA a N d SD

11. With proper explanation and practice, parents will be able to take their child's temperature and write it on a record form.

SD d N a SA

12. Most mothers should be allowed to change simple bandages provided they have been instructed by the nurse and call her if necessary.

SD d N a SA

13. Explaining a medically difficult procedure to a parent usually fails to make the parent feel more at ease.

SA a N d SD

14. The presence of a parent staying overnight is good for the child and the parent.

SD d N a SA

15. The mother who insists on staying with her child is usually a very upset person.

SA a N d SD

16. Parents are able to measure the urine output of their child and can write down the amount on a record form.

SD d N a SA

17. Parents should be allowed to visit the hospital whenever they wish.

SD d N a SA

18. In procedures in which the child needs to be restrained, such as in giving injections, a parent can often carry out this function.

SD d N a SA

19. If a child dies, it is usually better for the parent to be absent from the room.

SA a N d SD

20. Mothers should be encouraged to stay in the hospital through such means as free meals, bus fare and so on.

SA a N d SD

21. With proper explanation and practice, parents feel completely comfortable in being responsible for taking a child's pulse and writing on a record form.

SD d N a SA

22. The mother who shows visible signs of being upset over her child's condition should not visit her child.

SA a N d SD

23. Nurses should always give medications to children even if the medication is one which a mother would give at home.

SD d N a SA

24. Most parents are not aware of when it is good for them to be with the child and when it is not.

SA a N d SD

25. It is usually better for a nurse to explain a procedure to a child than it is to have the parent do the explaining after having been instructed by the nurse, even if the parent is able to fully understand the procedure.

SA a N d SD

26. When parents stay beyond the regular visiting hours, the normal hospital routine is upset.

SA a N d SD

Appendix C.

DEMOGRAPHIC DATA

Age		_ _ _
Gender	Male	0
	Female	1
Marital Status	Single	0
	Married	1
	Divorced	2
	Widowed	3
	Common-law	4
Highest grade attained in school	less than grade 9	0
	grades 10,11,12	1
	post-secondary	2
Number of children at home		_____

Occupation	homemaker	0
	laborer	1
	professional	2
	other	3
present employment status outside the home	unemployed	1
	part-time	2
	full-time	3
Country of Origin	Canada	1
	United States	2
	South America	3
	Central America	4
	Asia	5
	Europe	6
	Other	7

Age respondent emigrated to Canada	0 - 19 years
	20 years or over
	Not Applicable
Primary Language spoken at home	_____
Preferred language spoken at home	_____
How many times has your child been hospitalized	0
	1
	2
	3 or greater

Questions or Comments:

Appendix D.

Cover Letter

Hello,

My name is Colleen Norris. I am a Master of Nursing student at the University of Alberta. As part of my studies, I want to know if parents of preschoolers would like to participate in the care of their hospitalized child. In addition, I am asking you some questions about your personal history. As you can see your name is not requested and will not be used at any time during the research. If your child is either 4, 5, or 6 years old, I would appreciate your filling in the following questionnaire and returning the consent form and the questionnaire to me in the brown envelope provided. If you have any questions you can contact me at 466-8521.

Thank-you for your help in my research.

Sincerely yours,

Colleen Norris

Appendix E.

PPAS Item Means

1. If a given procedure or treatment is explained to a parent in a clear and understanding manner, the parent will be better able to give the child the emotional support he needs.

Mean **3.56** Min 2.00 Max 4.00

2. The presence of a child's parent is usually comforting to him.

Mean **3.56** Min 0.00 Max 4.00

3. When a mother volunteers to feed a child other than her own and permission for such has been granted by the natural mother of the child, she should be allowed to do so provided such action is not medically contradicted.

Mean **3.27** Min 2.00 Max 4.00

4. Parents should be allowed to help their child bathe and brush his teeth or do things for him.

Mean **3.62** Min 0.00 Max 4.00

5. It is usually a good practice for parents to accompany their child to X-ray.

Mean **3.43** Min 1.00 Max 4.00

6. It is better for a mother to feed her own baby or child than it is for the nurse to do so, provided it is not medically contraindicated.

Mean **3.62** Min 2.00 Max 4.00

7. The relationship between the nurse and the child is improved by having the parent help with the child's hospital care.

Mean **3.32** Min 2.00 Max 4.00

8. Parents can notice a change in the skin color of their child and report this to the nurse.

Mean **3.00** Min 1.00 Max 4.00

9. If a mother is involved in the care of her very ill child, then she would usually have an easier time adjusting to the child's death should the child happen to die.

Mean **2.56** Min 0.00 Max 4.00

10. Generally, parents should not accompany their children to the X-ray room even after having observed the necessary precautions.

Mean **3.37** Min 1.00 Max 4.00

11. With proper explanation and practice, parents will be able to take their child's temperature and write it on a record form.

Mean **3.00** Min 0.00 Max 4.00

12. Most mothers should be allowed to change simple bandages provided they have been instructed by the nurse and call her if necessary.

Mean **2.97** Min 1.00 Max 4.00

13. Explaining a medically difficult procedure to a parent usually fails to make the parent feel more at ease.

Mean **2.94** Min 1.00 Max 4.00

14. The presence of a parent staying overnight is good for the child and the parent.

Mean **3.37** Min 2.00 Max 4.00

15. The mother who insists on staying with her child is usually a very upset person.

Mean **3.16** Min 0.00 Max 4.00

16. Parents are able to measure the urine output of their child and can write down the amount on a record form.

Mean **2.89** Min 1.00 Max 4.00

17. Parents should be allowed to visit the hospital whenever they wish.

Mean **3.51** Min 1.00 Max 4.00

18. In procedures in which the child needs to be restrained, such as in giving injections, a parent can often carry out this function.

Mean **2.72** Min 0.00 Max 4.00

19. If a child dies, it is usually better for the parent to be absent from the room.

Mean **3.59** Min 2.00 Max 4.00

20. Mothers should be encouraged to stay in the hospital through such means as free meals, bus fare and so on.

Mean 2.75 Min 0.00 Max 4.00

21. With proper explanation and practice, parents feel completely comfortable in being responsible for taking a child's pulse and writing on a record form.

Mean **2.59** Min 0.00 Max 4.00

22. The mother who shows visible signs of being upset over her child's condition should not visit her child.

Mean **3.13** Min 1.00 Max 4.00

23. Nurses should always give medications to children even if the medication is one which a mother would give at home.

Mean **2.13** Min 0.00 Max 4.00

24. Most parents are not aware of when it is good for them to be with the child and when it is not.

Mean **2.94** Min 0.00 Max 4.00

25. It is usually better for a nurse to explain a procedure to a child than it is to have the parent do the explaining after having been instructed by the nurse, even if the parent is able to fully understand the procedure.

Mean **2.54** Min 1.00 Max 4.00

26. When parents stay beyond the regular visiting hours, the normal hospital routine is upset.

Mean **3.16** Min 2.00 Max 4.00

Appendix F.
Table for Scoring Dominant Value Preferences.

RESPONDENT # _____ **PPAS** _____

QUESTION	VOQ #	CHOICE 1	CHOICE 2	CHOICE 3
1	A1			
1	A2			
15	A3			
17	A4			
20	A5			
21	A6			
	ACTIVITY			
2	R1			
7	R2			
8	R3			
9	R4			
12	R5			
16	R6			
17	R7			
	RELATIONAL			
3	T1			
5	T2			
11	T3			
14	T4			
19	T5			
	TIME			
4	MN1			
6	MN2			
10	MN3			
13	MN4			
18	MN5			